STAFF: _____

Family Information

Today's Date: _____

Please List the Names and Dates of Birth of the Children in the Family:

Name: _____ DOB_____ Name: _____ DOB_____

Name: _____ DOB_____ Name: _____ DOB_____

Who may we thank for referring you to our office? _____

E-Mail Address (For Reminders): _____

Emergency Contact: _____ Relationship: _____ Phone: (____) _____
(Please list someone other than yourself)

Primary Responsible Party Information:

Parent Name: _____ □ Male □ Female Birth Date: _____
□ Parent □ Step-Parent □ Legal Guardian (Documentation Required) □ Foster Parent (Documentation Required)
Address: _____
City: _____ State: _____ Zip: _____
Primary Phone: (_____) _____ □ Home □ Cell □ Work
Secondary Phone: (_____) _____ □ Home □ Cell □ Work

Secondary Responsible Party Information:

Parent Name: _____ □ Male □ Female Birth Date: _____
□ Parent □ Step-Parent □ Legal Guardian (Documentation Required) □ Foster Parent (Documentation Required)
Address: _____
City: _____ State: _____ Zip: _____
Primary Phone: (_____) _____ □ Home □ Cell □ Work
Secondary Phone: (_____) _____ □ Home □ Cell □ Work

Insurance Information:

□ Check Here if Provider One/Apple Health and list Child(s) Name and Provider One ID#. *(Nine Digit Number ending in WA)*
Child: _____ID#: _____ Child: _____ ID#:_____
Child: _____ID#: _____ Child: _____ ID#: _____

Dental Insurance Information:

Primary Ins. Subscriber Name: _____
Primary Subscriber DOB: _____
Primary Dental Insurance: _____
Primary Subscriber's Employer: _____
Group #: _____ Phone #: _____
Subscriber ID or SS#: _____

**If billing secondary required to update Coordination of Benefits with both ins. companies.*

Secondary Ins. Subscriber Name: _____
Secondary Subscriber DOB: _____
Secondary Dental Insurance: _____
Secondary Subscriber's Employer: _____
Group #: _____ Phone #: _____
Subscriber ID or SS#: _____

I am legally authorized to obtain medical/dental services for this patient. The questions on this form have been accurately answered. I authorize the dental staff to perform the necessary dental services my child may need. I authorize and request my insurance company to pay directly to the dentist or dentists' group insurance benefits otherwise payable to me. ***By signing below I understand that I am financially responsible for payment of all services rendered on my dependents' behalf.***

_____/_____ _____
Signature of Parent or Legal Guardian Print Name Date

Puget Sound Pediatric Dentistry

Office & Financial Policies

As a courtesy, we are able to forward claims to your insurance carrier however, your estimated co-payments are *due at the time of treatment*. Your insurance company will provide benefits according to the provision of your particular policy. It is in your best interest to understand your own insurance plan and any limitations it may have. In this regard we would like to offer you a few tips:

- Please provide our office with your insurance card or benefit booklet prior to any visits. If your plan pays by a fee schedule, you must provide us with that schedule, as some insurance companies will not release this information to us.
- Remember that most plans only pay a portion of your treatment costs, regardless of any financial estimates we provide you with. We cannot guarantee what your insurance will pay until we submit the claim itself. You, the financially responsible party, are accountable in full for any amount not paid by your insurance.
- We are considered an in-network provider with most Delta Dental PPO and Premier Plans, Regence, Premera, Aetna, MetLife, Cigna, United Concordia, Assurant, Guardian, and HMA.
- Insurance claims not paid within 60 days may become your responsibility.

If you wish, you may use Visa or MasterCard. Our office does offer monthly payments plans through an outside lender, Care Credit. Please inquire with our office staff for more information. In addition Puget Sound Pediatric Dentistry will apply a $35.00 NSF fee for all returned checks. I give my consent to Puget Sound Pediatric Dentistry and to any of its agents acting on its behalf to communicate with me regarding my accounts through various means such as 1) any cell, landline, or text number that I provide 2) any email address that I provide, 3) auto dialer systems 4) voicemail messages, and other forms of communications.

Scheduling an appointment is considered a confirmation. Since our specialty is kids, we understand that you juggle school, activities, family commitments, and may occasionally need to change your scheduled appointments. Our office will provide you with complimentary hygiene reminder cards, an e-mail/text message prior to any appointment, as well as a phone call the day before your scheduled time, or Friday for all Monday appointments. As we will have reserved that time especially for your family please call us at least 48 hours in advance if you need to find another time that works. We reserve the right to charge a broken appointment fee in the amount of $35.00 for hygiene appointments and $50.00/hour for restorative appointments. All patients must abide by our appointment cancelation policy; if an appointment is missed without sufficient notice we will have no recourse but to dismiss your family. In addition, if you are running late for an appointment we will be able to see your child *no later* than 10 minutes past their original scheduled time.

Notice of Privacy Practices

I certify that I have reviewed, received a copy or am aware of Puget Sound Pediatric Dentistry Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services or in the performance of office's health care operations. The Notice of Privacy Practices also describes my rights and Puget Sound Pediatric Dentistry's duties with respect to my protected health information. I authorize Puget Sound Pediatric Dentistry to disclose my child's protected health information (PHI) only in the specific manner, for the named reason, and to the specific individuals listed below.

I authorize Puget Sound Pediatric Dentistry to send films and/or reports containing my child's PHI consisting of name, date of birth, case number, date and nature of any clinical history to any other physicians and healthcare providers that request this information to perform treatment and/or consultation regarding my child's dental health.

I authorize Puget Sound Pediatric Dentistry to send reports containing my child's PHI consisting of name, date of birth, social security number, address, insurance information, date of and description of any clinical history to their billing department and agencies connected with the billing department to carry out request for payment for treatment.

Puget Sound Pediatric Dentistry will continue to send post card reminders; leave detailed voicemail and messages to confirm, change or notify you of your appointment, and discuss billing unless specifically requested otherwise by patient.

I understand and acknowledge Puget Sound Pediatric Dentistry's Notice of Privacy Practices/ Office and Financial Policies. At any time a full detailed copy of the HIPPA privacy act and Office/Financial Polices is available to me if I so choose to have one.

Name of Patient(s): _____

Signature of Legal Guardian: _____ Date: _____

Print Name: _____

Description of Legal Guardian's Authority (Relationship to Patient): _____